General

Guideline Title

VA/DoD clinical practice guideline for assessment and management of patients at risk for suicide.

Bibliographic Source(s)

Assessment and Management of Risk for Suicide Working Group. VA/DoD clinical practice guideline for assessment and management of patients at risk for suicide. Washington (DC): Department of Veterans Affairs, Department of Defense; 2013 Jun. 190 p.

Guideline Status

This is the current release of the guideline.

Regulatory Alert

FDA Warning/Regulatory Alert

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- March 22, 2016 – Opioid pain medicines: The U.S. Food and Drug Administration (FDA) is warning about several safety issues with the entire class of opioid pain medicines. These safety risks are potentially harmful interactions with numerous other medications, problems with the adrenal glands, and decreased sex hormone levels. They are requiring changes to the labels of all opioid drugs to warn about these risks.

Recommendations

Major Recommendations

Note from the Department of Veterans Affairs and the Department of Defense (VA/DoD) and the National Guideline Clearinghouse (NGC): The recommendations for the assessment and management of patients at risk for suicide are organized into 4 modules with 3 algorithms. The modules with accompanying recommendations are presented below. See the original guideline document for the algorithms and evidence tables associated with selected recommendations, including level and quality of evidence, strength of recommendation, and supporting evidence citations.

The strength of recommendation grading (A, B, C, D, I) is defined at the end of the "Major Recommendations" field.

Module A: Assessment and Determination of Risk for Suicide

A. Person Suspected to Have Suicidal Thoughts (Ideation), a Recent Previous Suicide Attempt, or Self-directed Violence Episodes
    1. Any patient with the following conditions should be assessed and managed using this guideline:
        a. Person is identified as possibly having risk for suicide during evaluation and management of mental disorders (depression, bipolar, schizophrenia, post-traumatic stress disorder [PTSD]), or medical condition (traumatic brain injury [TBI], pain, sleep disturbance) known to be associated with increased risk for suicide
        b. Person reports suicidal thoughts on deployment-related assessments (e.g., Post-Deployment Health Assessment/Post-Deployment Health Reassessment [PDHA/PDHRA]), or on annual screening tools, or other evaluation such as mental health intake
        c. Person scores very high on depression screening tool and is identified as having concerns of suicide
        d. Person reports suicidal thoughts on depression screening tool
        e. Woman reports suicidal thoughts on depression screening tool during pregnancy or postpartum visits
        f. Person is seeking help (self-referral) and reporting suicidal thoughts
        g. Service member referred to health care provider by command, clergy, or family/unit members who have expressed concerns about the person's behavior
        h. Person for whom the provider has concerns about suicide - based on the provider's clinical judgment
        i. Person with history of suicide attempt or recent history of self-directed violence

B. Assess Risk for Suicide

> Suicide risk assessment is a process in which the healthcare provider gathers clinical information in order to determine the patient's risk for suicide. The risk for suicide is estimated based on the patient's suicidal thoughts and intent, suicide related behavior, warning signs, risk and protective factors.

1. A suicide risk assessment should first evaluate the three domains: suicidal thoughts, intent, and behavior including warning signs that may increase the patient's acuity. (See Annotation C.)
2. The suicide risk assessment should then include consideration of risk and protective factors that may increase or decrease the patient's risk of suicide. (See Annotation D.)
3. Observation and existence of warning signs and the evaluation of suicidal thoughts, intent, behaviors, and other risk and protective factors should be used to inform any decision about referral to a higher level of care. (See Annotation E.)
4. Mental state and suicidal ideation can fluctuate considerably over time. Any person at risk for suicide should be re-assessed regularly, particularly if their circumstances have changed.
5. The clinician should observe the patient's behavior during the clinical interview. Disconnectedness or a lack of rapport may indicate increased risk for suicide.
6. The provider evaluating suicide risk should remain both empathetic and objective throughout the course of the evaluation. A direct non-judgmental approach allows the provider to gather the most reliable information in a collaborative way, and the patient to accept help.

C. Assessment of Suicidal Ideation, Intent and Behavior

> Assess the patient's thoughts of suicide, the intention to act on those thoughts, and behaviors that demonstrate warning signs.

C1. Suicidal Ideation/Thoughts

> Ask the patient if he/she has thoughts about wishing to die by suicide, or thoughts of engaging in suicide-related behavior. The distinction between non-suicidal self-directed violence and suicidal behavior is important.

1. Patients should be directly asked if they have thoughts of suicide and to describe them. The evaluation of suicidal thoughts should include the following:
    a. Onset (When did it begin)
    b. Duration (Acute, Chronic, Recurrent)

c. Intensity (Fleeting, Nagging, Intense)
d. Frequency (Rare, Intermittent, Daily, Unabating)
e. Active or passive nature of the ideation ('Wish I was dead' vs. 'Thinking of killing myself')
f. Whether the individual wishes to kill themselves, or is thinking about or engaging in potentially dangerous behavior for some other reason (e.g., cutting oneself as a means of relieving emotional distress)
g. Lethality of the plan (No plan, Overdose, Hanging, Firearm)
h. Triggering events or stressors (Relationship, Illness, Loss)
i. What intensifies the thoughts
j. What distracts the thoughts
k. Association with states of intoxication (Are episodes of ideation present or exacerbated only when individual is intoxicated? This does not make them less serious; however may provide a specific target for treatment)
l. Understanding regarding the consequences of future potential actions.

C2. Suicidal Intent

Assess for past or present evidence (implicit or explicit) that the individual wishes to die, means to kill him/herself, and understands the probable consequences of his/her actions or potential actions.

1. Patients should be asked the degree to which he/she wishes to die, mean to kill him/herself, and understand the probable consequences of his/her actions or potential actions
2. The evaluation of intent to die should be characterized by:
    a. Strength of the desire to die
    b. Strength of determination to act
    c. Strength of impulse to act or ability to resist the impulse to act.
3. The evaluation of suicidal intent should be based on indication that the individual:
    a. Wishes to die
    b. Means to kill him/herself
    c. Understands the probable consequences of the actions or potential actions
    d. These factors may be highlighted by querying regarding how much the individual has thought about a lethal plan, has the ability to engage that plan, and is likely to carry out the plan.

C3. Preparatory Behavior

Assess if the patient has begun to show actual behavior of preparation for engaging in self-directed violence (e.g., assembling a method, preparing for one's death).

1. Clinicians should evaluate preparatory behaviors by inquiring about:
    a. Preparatory behavior like practicing a suicide plan. For example:
        - Mentally walking through the attempt
        - Walking to the bridge
        - Handling the weapon
        - Researching for methods on the internet
    b. Thoughts about where they would do it and the likelihood of being found or interrupted
    c. Action to seek access to lethal means or explored the lethality of means. For example (see Annotation D5):
        - Acquiring a firearm or ammunition
        - Hoarding medication
        - Purchasing a rope, blade, etc.
        - Researching ways to kill oneself on the internet
    d. Action taken or other steps in preparing to end one's life:
        - Writing a will, suicide note
        - Giving away possessions
        - Reviewing life insurance policy
2. Obtain collateral information from sources such as family members, medical records, and therapists.

C4. Previous Suicide Attempt

Obtain information from the patient and other sources about previous suicide attempts. Historical suicide attempts may or may not have resulted in injury, and may have been interrupted by the patient or by another person prior to fatal injury.

1. The assessment of risk for suicide should include information from the patient and collateral sources about previous suicide attempt and circumstances surrounding the event (i.e., triggering events, method used, consequences of behavior, role of substances of abuse) to determine the lethality of any previous attempt:
    a. Inquire if the attempt was interrupted by self or other, and other evidence of effort to isolate or prevent discovery
    b. Inquire about other previous and possible multiple attempts
    c. For patients who have evidence of previous interrupted (by self or other) attempts, obtain additional details to determine factors that enabled the patient to resist the impulse to act (if self-interrupted) and prevent future attempts.

C5. Warning Signs – Indications for Urgent/Immediate Action

Recognize precipitating emotions, thoughts, or behaviors that are most proximally associated with a suicidal act and reflect high risk.

1. Assess for other warning signs that may indicate likelihood of suicidal behaviors occurring in the near future, and require immediate attention:
    - Substance abuse – increasing or excessive substance use (alcohol, drugs, smoking)
    - Hopelessness – expresses feeling that nothing can be done to improve the situation
    - Purposelessness – expresses no sense of purpose, no reason for living, decreased self-esteem
    - Anger – rage, seeking revenge
    - Recklessness – engaging impulsively in risky behavior
    - Feeling trapped – expressing feelings of being trapped with no way out
    - Social withdrawal – withdrawing from family, friends, society
    - Anxiety – agitation, irritability, angry outbursts, feeling like wants to "jump out of my skin"
    - Mood changes – dramatic changes in mood, lack of interest in usual activities/friends
    - Sleep disturbances – insomnia, unable to sleep or sleeping all the time
    - Guilt or shame – expressing overwhelming self-blame or remorse.

D. Assessment of Factors That Contribute to the Risk for Suicide

Assess factors that are known to be associated with suicide (i.e., risk factors, precipitants) and those that may decrease the risk (i.e., protective factors).

1. Providers should obtain information about risk factors during a baseline evaluation – recognizing that risk factors have limited utility in predicting future behavior.
2. Providers should draw on available information including prior history available in the patient's record, inquiry and observation of the patient, family or military unit members and other sources where available.
3. Assessment tools may be used to evaluate risk factors, in addition to the clinical interview, although there is insufficient evidence to recommend one tool over another.
4. The baseline assessment should include information about risk factors sufficient to inform further assessment if conditions change such as firearm in the home, social isolation, history of depression, etc.
5. Risk factors should be considered to denote higher risk individuals (e.g., those with a history of depression) and higher risk periods (e.g., recent interpersonal difficulties).
6. Risk factors should be solicited and considered in the formulation of a patient's care.
7. Reassessment of risk should occur when there is a change in the patient's condition (e.g., relapse of alcoholism) or psychosocial situation (e.g., break-up of intimate relationship) to suggest increased risk. Providers should update information about risk factors when there are changes in the individual's symptoms or circumstances to suggest increased risk.
8. Patients ages 18 to 25 who are prescribed an antidepressant are at increased risk for suicidal ideation and warrant increase in the frequency of monitoring of these patients for such behavior.
9. For Military Service person in transition the provider should:
    a. Inquire about changes in the patient's life and be aware of other indicators of change (retirement physical, overseas duty screening, etc.).

b. Be willing to discuss and consider methods to strengthen social support during the transition time if there are other risk factors present.

D1. Risk Factors/Precipitants

Risk factors distinguish a higher risk group from a lower risk group. Risk factors may be modifiable or non-modifiable and both inform the formulation of risk for suicide. Modifiable risk factors may also be targets of intervention.

D2. Impulsivity

1. The assessment of risk for suicide should include evaluation of impulsivity by determining whether the patient is feeling out of control, engaging impulsively in risky behavior.
2. Assess if impulsive recklessness and risk-taking characterize the pattern of behavior and lifestyle of the individual and therefore may limit the ability to control his/her behavior.

D3. Protective Factors

Protective factors are capacities, qualities, environmental and personal resources that drive individuals towards growth, stability, and health and may reduce the risk for suicide.

1. Assessment should include evaluation of protective factors, patient's reason for living, or other factors that mitigate the risk for suicide.
   Social Context Support System
   - Strong interpersonal bonds to family/unit members and community support
   - Employed
   - Intact marriage
   - Child rearing responsibilities
   - Responsibilities/duties to others
   - A reasonably safe and stable environment

   Positive Personal Traits
   - Help seeking
   - Good impulse control
   - Good skills in problem solving, coping and conflict resolution
   - Sense of belonging, sense of identity, and good self-esteem
   - Cultural, spiritual, and religious beliefs about the meaning and value of life
   - Optimistic outlook - identification of future goals
   - Constructive use of leisure time (enjoyable activities)
   - Resilience

   Access to Health Care
   - Support through ongoing medical and mental health care relationships
   - Effective clinical care for mental, physical and substance use disorders
   - Good treatment engagement and a sense of the importance of health and wellness

D4. Substance Abuse and Disorder

1. All patients at acute risk for suicide who are under the influence (intoxicated by drugs or alcohol) should be evaluated in an urgent care setting and be kept under observation until they are sober.
   a. Patients who are under the influence should be reassessed for risk for suicide when the patient is no longer acutely intoxicated, demonstrating signs or symptoms of intoxication, or acute withdrawal.
   b. Obtaining additional information from family members, treatment providers, medical records, etc., can be invaluable in making the determination between intentional and unintentional overdose in equivocal cases.
   c. Intoxicated or psychotic patients who are unknown to the clinician and who are suspected to be at acute risk for suicide should be transported securely to the nearest crisis center or emergency department for evaluation and management. These patients can be dangerous and impulsive; assistance in transfer from law enforcement may be considered.
2. Intoxication with drugs or alcohol impairs judgment and increases the risk of suicide attempt. Use of drugs or alcohol should routinely

be assessed with all persons at any risk for suicide.

3. Assess the presence of psychiatric and behavioral comorbidities (e.g., mood, anxiety disorder, aggression) in patients with substance use disorder at risk for suicide.
4. Recognize that assessment of social risk factors such as disruptions in relationships and legal and financial difficulties are important in individuals with substance use disorders.

D5. Assess Access to Lethal Means

> Assess the availability or intent to acquire lethal means including firearms and ammunition, drugs, poisons and other means in the patient's home. For Service members, this includes assessing privately owned firearms.

1. Assessment of presence and access to lethal means should include:
    a. Firearms: Always inquire about access to firearms and ammunition (including privately-owned firearm) and how they are stored.
    b. Medications: Perform medication reconciliation for all patients. For any current and/or proposed medications consider the risk/benefit of any medications which could be used as a lethal agent to facilitate suicide. Consider prescribing limited supplies for those at elevated risk for suicide, or with histories of overdose or the availability of a caregiver to oversee the administration of the medications.
    c. Household poisons: Assess availability of chemical poisons, especially agricultural and household chemicals. Many of these are highly toxic.

E. Determine the Level of Risk (Severity of Suicidality)

> Determine the level of the risk for suicidal self–directed violence to establish the appropriate setting of care and to implement treatment interventions targeting the specific level of risk.

1. Patients at HIGH ACUTE RISK should be immediately referred for a specialty evaluation with particular concern for insuring the patient's safety and consideration for hospitalization.
2. Patients at INTERMEDIATE ACUTE RISK should be evaluated by Behavioral Health specialty.
3. Patients at LOW ACUTE RISK should be considered for consultation with or referral to a Behavioral Health Practitioner.
4. Patients at NO elevated ACUTE RISK should be followed in routine care with treatment of their underlying condition, and evaluated periodically for ideation or suicidal thoughts.
5. Patient for whom the risk remains UNDETERMINED (no collaboration of the patient or provider concerns about the patients despite denial of risk) should be evaluated by a by Behavioral Health Practitioner.

Refer to Table 1 in the original guideline document for information on how to determine level of risk for suicide and appropriate action in primary care.

E1. Suicide Risk Assessment Instruments

> Risk factors can inform the assessment for any given individual, but are not predictive by themselves. While suicide risk assessment scales are no substitute for comprehensive evaluation and clinical judgment based on the history of the person, they may provide a structure for systematic inquiry about risk factors for repeated suicide attempts.

1. Formulation of the level of suicide risk should be based on a comprehensive clinical evaluation that is aimed to assess suicidal thoughts, intent and behavior and information about risk and protective factors for estimating the level of risk.
2. Behavioral Health provider use of a standardized assessment framework may serve to inform a comprehensive clinical evaluation. The framework should:
    a. Estimate the level of risk
    b. Support clinical decision-making
    c. Determine the level of intervention and indication for referral
    d. Allow monitoring of risk level over time
    e. Serve as the foundation for clinical documentation
    f. Facilitate consistent data collection for process improvement

3. Assessment of risk for suicide should not be based on any single assessment instrument alone and cannot replace a clinical evaluation. The assessment should reflect the understanding (recognizing) that an absolute risk for suicide cannot be predicted with certainty.
4. There is insufficient evidence to recommend any specific measurement scale to determine suicide risk.

E2. Detection, Recognition and Referral (in Primary Care)

Assessment of Suicide Risk in the Primary Care Settings

1. Whether they have mental disorder or not, patients identified as having suicidal ideation (e.g., through routine screening for major depression or other health conditions) should receive a complete suicide risk assessment as defined in this guideline (see Annotation B).
2. When evidence of a mood, anxiety, or substance use disorder is present, patients should be asked about suicidal thoughts and behavior directly.
3. If suicidal ideation is present, the initial suicide risk assessment should be performed (see Annotation B).
4. Referral to specialty behavioral health care should be based on the level of risk and the available resources:
    a. Patients at HIGH ACUTE RISK should remain under constant observation and monitoring before arranging for immediate transfer for psychiatric evaluation or hospitalization.
    b. Patients at INTERMEDIATE ACUTE RISK should be referred to, and managed by, Behavioral Health Specialty Provider.
    c. Patients at LOW ACUTE RISK should be considered for consultation with a Behavioral Health Practitioner.
    d. When risk is UNDETERMINED (due to difficulty in determining the level of risk, or provider concerns about the patient despite denial of ideation or intent) the patient should be immediately referred for an evaluation by a Behavioral Health Specialty Provider.

Guidance for the Assessment of Suicide Risk in Emergency Department/Urgent Care Settings

> Patient at HIGH ACUTE-RISK for suicide should be assessed and initially treated in emergency acute care setting.

1. Providers should choose the setting for the initial evaluation to ensure the safety of the patient and the clinical staff so that potentially life-threatening conditions can be managed effectively. And make the appropriate steps to:
    a. Secure all belongings to prevent access to lethal means and elopement from the Emergency Department.
    b. Monitor the patient in a visible area, away from exits, with limited access to equipment that may be used to harm self or others.
    c. Conduct a focused medical assessment to identify and manage any life-threatening conditions such as overdose, and assess medical stability.
        - Vital signs, physical exam, neurologic exam, mental status exam.
        - Electrocardiogram (ECG), toxicology screen, blood-alcohol level (BAL), and other tests as indicated.
        - Treat life-threatening conditions.
    d. Request Behavioral Health Consultation to conduct a thorough suicide risk assessment and recommend a treatment plan.

E3. Comprehensive Assessment for Risk for Suicide by Behavioral Health Provider

> An experienced behavioral health practitioner should evaluate patients at intermediate to high acute risk for suicide.

1. Gather collateral history from family/unit members, the medical record, escorts, unit commanders (or their representatives), referring physicians, emergency medical services (EMS), and police as appropriate.
2. Approach the patient with a non-judgmental, collaborative attitude with the aim of fully understanding the patient's suicidality.
3. Secure all belongings to prevent access to lethal means and elopement from the clinic.
4. Choose the setting for the initial evaluation to ensure the safety of the patient and the clinical staff so that potentially life-threatening conditions can be managed effectively. If the patient is intoxicated, re-evaluate when intoxication has resolved.
5. Conduct a mental status examination and a comprehensive assessment of mental health history that includes:
    a. Past and present suicidal thoughts, intent, and behaviors, impulsivity, hopelessness and the patient view of the future.
    b. Alcohol use assessed per standardized tools (Alcohol Use Disorders Identification Test—Consumption [AUDIT-C]), and other substance abuse history, since impaired judgment may increase the severity of the suicidality and risk for suicide act.
    c. Psychiatric illness, comorbid diagnoses, and history of treatment interventions.
    d. Elicit family history of suicidal behavior.
6. Assess for access and past use of lethal means (firearms, drugs, toxic agents).
7. Assess social history of support system, living situation and potential stressful life events.

8. Consider suicidal thinking, intent, behavior, risk factors and protective factors to stratify the risk.
9. Consider the use of a standardized suicide risk assessment framework to inform the evaluation for estimating the risk for suicide.
10. Determine appropriate setting for further evaluation and management based on level of risk, legal guidance, and local policy.
11. Document in detail the data supporting the assigned level of risk, the level of care required, and treatment plans to reduce suicide risk.

Module B: Initial Management of Patient at Risk for Suicide

F. Determine the Appropriate Care Setting

F1. Matching Care Level to Level of Risk

> Choose the appropriate care setting that provides the patient at risk of suicide maximal safety in the least restrictive environment.

1. Consider hospitalization for patients at high acute risk for suicide who need crisis intervention, intensive structure and supervision to ensure safety, management of complex diagnoses, and delivery of intensive therapeutic procedures.
2. The inpatient psychiatric hospital setting is particularly suitable for the treatment of acute risk for suicide rather than chronic risk.
3. An individualized treatment plan should be determined to meet the patient's needs and aimed to allow as much self-control and autonomy as possible, balanced against the risk level.
4. Although suicidality may persist, the treatment goal is to transition the patient toward a less restrictive environment based on clinical improvement and the assessment that the suicide risk has been reduced.

F2. Criteria for Transition to Less Restrictive Settings

1. A patient may be discharged to a less restrictive level of care from an acute setting (emergency department/hospital/acute specialty care) after a behavioral health clinician evaluated the patient, or a behavioral health clinician was consulted, and all three of the following conditions have been met:
    a. Clinician assessment that the patient has no current suicidal intent
    AND
    b. The patient's active psychiatric symptoms are assessed to be stable enough to allow for reduction of level of care.
    AND
    c. The patient has the capacity and willingness to follow the personalized safety plan (including having available support system resources).

F3. Hospitalization

> Despite insufficient evidence to demonstrate the effectiveness of acute hospitalization in the prevention of suicide, hospitalization is indicated in suicidal patients who cannot be maintained in less restrictive care setting.

1. Any patient with suicidal intent or behavior who cannot be maintained in a less restrictive environment requires hospitalization in order to provide an optimal controlled environment to maintain the patient's safety and initiate treatment.
2. A complete biopsychosocial assessment should be performed upon hospitalization to determine all direct and indirect contributing factors to suicidal thoughts and behaviors. Patient and family education should be provided on techniques to manage these factors.

F4. Partial Hospitalization, Intensive Outpatient Program (IOPs)

1. There is insufficient evidence to recommend that partial hospitalization is preferable to other treatment settings for reducing the risk of suicide.

F5. Discharge Planning

1. A collaborative discharge plan should be developed to allow a suicidal patient to be discharged from inpatient psychiatric care or the Emergency Department in order to mitigate the increased risk of suicide post discharge.
2. Patients who are discharged from acute care (hospitalization, Emergency Department) remain at high risk for suicide and should be followed up within seven days of discharge.
3. Discharge planning should include the following:
    a. Re-assessment of the suicide risk
    b. Education to patient and support system about the risks of suicide in the post-discharge timeframe
    c. Providing suicide prevention information (such as a crisis hotline) to the patient and family/unit members
    d. Post-discharge treatment plans for psychiatric conditions and for suicide-specific therapies

e. Safety plan with validation of available support systems
f. Coordination of the transition to appropriate care setting with warm hand-offs
g. Identifying the responsible provider during the transition
h. Monitoring of adherence to the discharge plan for 12 weeks

(For further recommendations see Module D: Follow-up and Monitoring.)

G. Securing Patient's Safety

G1. Education for Patient and Family

> Health care professionals should provide adults and their families/caregivers/command, if appropriate, with education regarding suicide, stigma, treatment options, and management strategies.

1. The patient should be educated about conditions that are associated with their suicidal crisis, factors that increase and decrease their risk of suicide, and the risks and benefits associated with treatment options included in the treatment plan to target suicidality and associated conditions.
2. Patient and family should receive information about the resources available through the Veterans or Military Crisis Line (including phone, chat and text services).
3. The patient and family education should be done with empathy, and appropriate respect for autonomy and patient privacy. Family/unit members should be engaged with the patient consent. This education should aim to instill hope of recovery and reduce stigma and shame.
4. Strongly recommend advising all patients at intermediate to high acute risk for suicide against the use of alcohol and non-prescribed medications, and educate on the potential for drug-drug and drug-alcohol interactions that can impair decision-making and increase the risk of impulsive suicide attempts.
5. Patient and family education should be provided with the following characteristics:
    a. Tailored to the needs (e.g., language and educational level) and situational factors of the identified family or supports and patient
    b. Ensure specific focus on self-directed violence or suicide behaviors
    c. Allow plenty of time to answer patient and family member questions and establish a collaborative relationship.
6. At a minimum, patient and family education should include:
    a. The nature of self-directed violence or suicide behaviors, the episodic recurrent nature of suicide risk and the applicable biological, cognitive, emotional, or psychosocial risk factors
    b. The impact of any existing psychiatric diagnoses or high risk situational stresses
    c. Risk factors associated with suicide
    d. Warning signs, reviewing any particular warning signs the patient may have demonstrated prior to any attempts or reported ideation
    e. The protective role of positive family relationships and the potential harmful impact of negative family interaction on risk mitigation
    f. The importance of assisting the patient with his/her safety plan and means restriction, removing potentially lethal means of self-harm (e.g., firearms, medications, knives, or razor blades) from the person and their home environment, particularly if the person has mentioned specific means
    g. Methods for contacting the patient's provider and other medical or community support resources (e.g., hotlines) should the family member become concerned
    h. The importance of encouraging the patient to comply with a collaboratively established treatment plan and follow-up care.

G2. Limiting Access to Lethal Means (Firearms, Drugs, Toxic Agents, Other)

> Consider ways to restrict access to lethal means that Service members/veterans could use to take their own lives. This includes, among others, restriction of access to firearms and ammunition, safer prescribing and dispensing of medications to prevent intentional overdoses, and modifying the environment of care in clinical settings to prevent fatal hangings. For Service members concerns about firearms must include privately owned guns and ammunition.

1. Provide education about actions to reduce associated risks and measured to limit the availability of means with emphasis on more lethal methods available to the patient:

a. Firearms (military or privately owned): For patients at highest risk, exercise extreme diligence to ensure firearms are made inaccessible to the patient. For all patients at intermediate to high acute risk of suicide, discuss the possibility of safe storage of firearms with the patient, command, and family (e.g., lock firearms up; use trigger locks or store firearms at the military armory, at a friend's home, or local police station; store ammunition separately).
b. Medications: When clinically possible, include limiting access to medications that carry risk for suicide, at least during the periods when patient is at high acute risk for suicide. This may include prescribing limited quantities, supplying the medication in blister packaging, providing printed warnings about the dangers of overdose, or ensuring that currently prescribed medications are actively controlled by a responsible party.
c. Household Poisons: Educate how to secure chemical poisons, especially agricultural and household chemicals, to prevent accidental or intentional ingestions. Many of these chemicals are highly toxic.

G3. Safety Plan for Patient at Risk of Suicide

Establish an individualized Safety Plan for all persons who are at high acute risk for suicide as part of discharge planning, regardless of inpatient or outpatient status. The Safety Plan is designed to empower the patient, manage the suicidal crisis, and engage other resources. Discuss safety with patients at intermediate and low risk and consider offering education about safety, and a copy of a Safety Plan handout.

1. Safety planning that is developed collaboratively with the patient should be part of discharge planning for all patients who were evaluated with high acute risk for suicide before being released to a lower level of care.
2. For patients at intermediate acute risk for suicide, the safety planning process can be abbreviated to recognizing signs of elevating safety concerns and listing of practical steps for individual coping, safety precautions and support-seeking.
3. For patient at low risk, provider should discuss signs that the patient can use to recognize escalating stress or risk, provide key phone numbers and resources for help, and educate about lethal means restriction. A handout can be used to reinforce the discussion.
4. A safety plan should be:
    a. Collaborative between the provider team and the patient
    b. Proactive–by explicitly anticipating a future suicidal crisis
    c. Individually tailored
    d. Oriented towards a no-harm decision
    e. Based on existing social support
5. The safety plan should include the following elements, as appropriate:
    a. Early identification of warning signs or stressors
    b. Enhancing coping strategies (e.g., to distract and support)
    c. Utilizing social support contacts (discuss with whom to share the plan)
    d. Contact information about access to professional help
    e. Minimizing access to lethal means (such as weapons and ammunition or large quantities of medication)
6. The development of the safety plan with the person, family/unit members, should anticipate and discuss contingencies to address possible obstructions to plan implementation and where to keep the plan.
7. The safety plan should be reviewed and updated by the health care team working with the patient as needed and shared with family/unit members and other related persons if the patient consents.
8. Safety plans should be updated to remain relevant during changes in clinical state and transitions of care.
9. Providers should document the safety plan within the medical record or reasons for not completing such a plan (i.e., "Patient admitted. Inpatient provider to complete safety plan at time of discharge.").

Refer to the original guideline document for information about components the of safety plan.

G4. No-Suicide Contracts

There is no empirical evidence for the usage of "no harm" or "no-suicide" contracts. A safety plan is a preferred strategy for preventing suicide.

1. Recommend against the use of no-suicide contracts as intervention to prevent future suicide in patients at high acute risk for suicide.
2. Patient management should include a comprehensive evaluation of current risk factors and warning signs for suicide, a personalized safety plan that best anticipates triggers for future suicidal thoughts and collaboratively develops coping strategies that make sense for the individual patient.

G5. Addressing Needs (Engaging Family, Community; Spiritual and Socioeconomic Resources)

1. Providers should consider psychosocial interventions to address unique family, social, cultural, spiritual and socioeconomic needs of the individual identified by the treatment team and patient.
2. Providers should refer the patient to available psychosocial resources to address the identified individual patient needs.
3. Provider should maintain awareness of available coping skills programs and use clinical judgment in determining if a particular patient will benefit from referral or inclusion in such a program. These modalities may not be appropriate for some Service members.
4. Underlying psychosocial factors impacting the provision of care may include:
    a. Unemployment
    b. Homelessness or housing instability
    c. Financial difficulties
    d. Legal issues
    e. Lack of social support (i.e., self-induced or circumstantial)
    f. Substance abuse
    g. Inability to coordinate comprehensive care
    h. Spiritual issues

Refer to Table B-2 in the original guideline document for more information for adjunctive problem focused methods and services.

G6. Additional Steps for Management of Military Service Members

1. Providers must take reasonable steps to limit the disclosure of Protected Health Information (PHI) to the minimum necessary to accomplish the intended purpose.
2. Providers should involve command in the treatment plan of Service member at high acute risk for suicide to assist in the recovery and the reintegration of the patient to the unit. For Service members at other risk levels, the provider should evaluate the risk and benefit of involving command and follow service Department policies, procedures, and local regulations.
3. When performing a medical profile, the provider should discuss with command the medical recommendation and the impact on the Service member's limitations to duty and fitness for continued service.
4. Provider should discuss with Service members the benefit of having command involved in their plan and assure them their rights to Protected Health Information with some exceptions regarding to the risk for suicide.
5. As required by pertinent military regulations, communicate to the Service member's chain of command regarding suicidal ideation along with any recommended restrictions to duty, health and welfare inspection, security clearance, deployment, and firearms access. Consider redeployment to home station any Service member deployed to a hazardous or isolated area.
6. Service members at high acute risk for suicide who meet criteria for hospitalization and require continuous (24-hour) direct supervision should be hospitalized in almost all instances. If not, the rationale should specifically state why this was not the preferred action with appropriate documentation.
7. During operational deployment conditions or other extreme situations during which hospitalization or evacuation is not possible, 'Unit watch' may be considered as appropriate in lieu of a high level care setting (hospitalization) and service Department policies, procedures, and local regulations should be followed.
8. Because of the high risk of suicide during the period of transition providers should pay particular attention to ensure follow-up, referral, and continuity of care during the transition of Service members at risk for suicide to a new duty station, after separation from unit, or separation from military service.

Module C: Treatment of the Patient at Risk for Suicide

H. Determine Treatment Plan

> Establish a treatment plan for patients at risk for suicide addressing the patient's potential (risk) for suicide, fostering the therapeutic alliance, and addressing mental health or medical disorders, and a range of available treatment alternatives from outpatient follow-up to hospitalization with constant observation and assurance of safety.

1. Patients should receive optimal evidence-based treatment for any mental health and medical conditions that may be related to the risk of suicide. Patients diagnosed with a mental health and/or medical condition should receive evidence-based treatments for their underlying condition following Evidence-based Clinical Practice Guidelines:
    - Substance Use Disorders (see the VA/DoD clinical practice guideline for management of substance use disorders [SUD])

- Major Depressive Disorder (see the NGC summary, VA/DoD clinical practice guideline for management of major depressive disorder [MDD])
- Bipolar Disorder (see the VA/DoD clinical practice guideline for management of bipolar disorder in adults)
- Post-traumatic Stress Disorder (see the VA/DoD clinical practice guideline for management of post-traumatic stress)
- Traumatic Brain Injury
- Chronic Pain (see the VA/DoD clinical practice guideline for management of opioid therapy for chronic pain)
- Medically Unexplained Symptoms (see the VA/DoD clinical practice guideline for management of medically unexplained symptoms: chronic pain and fatigue)

2. Care for the relevant condition-focused treatments may need to be modified to address the risk of suicide. For example, limiting the quantities of medications dispensed at any one time, enhancing social support, hospitalization and protection from harm, increasing the frequency of follow-up, increasing efforts to monitor and promote treatment adherence.
3. Treatment interventions that have been shown to be effective in reducing the risk for repeated self-directed violence or preventing suicide in patients with specific conditions need to be considered or optimized in those with these conditions who are at risk for suicide (e.g., lithium for patients with bipolar disorder, suicide-focused psychotherapy).
4. Family/unit members should be involved in the treatment plan when the patient consents. For Active Duty Service members the command should always be involved in the treatment plan of a high-risk suicidal patient.

I. Psychotherapy

Refer to the original guideline document for information about cognitive-behavioral therapy (CBT), problem solving therapy (PST), dialectical behavior therapy (DBT), interpersonal therapy (IPT), and psychodynamic therapies.

J. Suicide-Focused Psychotherapy Addressing the Suicide Risk

1. Suicide-focused psychotherapies that have been shown to be effective in reducing risk for repeated self-directed violence should be included in the treatment plan of patients at high risk for suicide, if the risk for suicide is not adequately addressed by psychotherapy specific to the underlying condition. Psychotherapy may include:
   a. Cognitive therapy for suicide prevention for non-psychotic patients who have survived a recent suicide attempt [B] and others at high risk. [I]
   b. PST that directly addresses the risk for suicide related behaviors for non-psychotic patients with more than one previous suicide attempt [B], and for other patients at high risk. [C]

K. Psychotherapy for Co-occurring Mental Disorders Associated with Suicide Risk

> When the self-harming behavior or suicide risk is associated with a psychiatric illness then that illness needs to be identified and treated and the treatment plan needs to be modified to specifically address the risk of suicide.

1. There is inconsistent evidence regarding the efficacy of psychotherapy in reducing the risk for repetition of self-directed violence in patients with co-occurring disorders. Specific psychotherapies may be considered in the following contexts:

K1. Risk for Suicide in Borderline Personality Disorder (BPD)

2. Dialectical Behavioral Therapy for patients with BPD or other personality disorders characterized by emotional dysregulation and a history of suicide attempts and/or self-harm. [I]
3. Specific psychotherapies based on cognitive or behavioral approaches or skills training (i.e., CBT for BPD, manual-assisted cognitive therapy [MACT], Acceptance Based Emotion Regulation Group Intervention) for patients with BPD who are at high risk for suicide. [I]
4. Specific psychodynamic psychotherapies (i.e., mentalization based therapy [MBT], brief psychodynamic IPT) for patients with BPD who are a high risk for suicide. [I]

K2. Borderline Personality Disorder

See the original guideline document for a discussion of the evidence for specific therapies.

K3. Risk for Suicide in Schizophrenia

There is insufficient evidence to recommend for or against use of CBT to reduce the risk of suicide behavior in patients with schizophrenia [I]

K4. Treatment of High Risk for Suicide and Comorbid Substance Use Disorder (SUD)

1. Ongoing management of suicidal patients with SUD should include treatment by a licensed mental health practitioner.
2. In addition to suicidality-focused interventions, treatment should be provided for an underlying SUD condition (e.g., addiction). Ensure that management of suicide risk is coordinated or integrated with treatment for SUD and comorbid conditions.
3. Intervention strategies in patients in whom suicide risk is associated with using substances should emphasize safety, relapse prevention, and address the substance use.
4. In the effort to limit access to lethal means, pay special attention in this population to restriction of lethal means as firearms, and prescribed medication (dosage and quantities).

L. Pharmacotherapy to Reduce Risk of Suicide

1. This Guideline recommends against the use of drug treatment as a specific intervention for prevention of self-directed violence in patients with no diagnosis of a mental disorder.
2. When a person expresses thoughts of self-harm or has demonstrated self-harm behavior, the patient's medication regimen (prescription drugs, over-the-counter medications, and supplements [e.g., herbal remedies]) should be reviewed for medications associated with suicidal thoughts or behavior. The continuation of such medications should be carefully evaluated and documented (see Appendix B-3 Table, "Drugs Associated with Suicidality," in the original guideline document).

M. Pharmacological Treatment to Reduce Risk for Suicide in Patients with Mental Disorders

> When self-harm behavior or suicide risk is attributable to a psychiatric illness, that illness needs to be identified and treated and the treatment plan modified when appropriate to specifically address the risk of suicide.

1. Pharmacological intervention may be markedly helpful in managing underlying mental disorders and the danger of repeated or more dangerous self-directed violence.
2. All medications (prescription drugs, over-the-counter medications, and supplements [e.g., herbal remedies]) used by patients at risk for suicide should be reviewed to assure effective and safe treatment without adverse drug interactions.
3. When prescribing drugs to people who self-harm, consider the toxicity of prescribed drugs in overdose and limit the quantity dispensed or available, and/or identify another person to be responsible for securing access to medications. The need for follow-up and monitoring for adverse events should also be considered.

M1. Use of Antidepressants to Prevent Suicide in a Patient with a Mood Disorder

> Closely monitor patients for changes in thoughts of suicide or suicidal behaviors after antidepressant treatment has been initiated or the medication dose is changed.

1. Antidepressants may provide benefit to address suicidal behavior in patients with mood disorders. Treatment for the underlying cause should be optimized according to evidence-based guidelines for the respective disorder.
2. Young adults (18-24) started on an antidepressant for treatment of depression or another psychiatric disorder should be monitored and observed closely for emergence or worsening of suicidal thoughts or behaviors during the initiation phase of treatment. [B]
3. Patients of all age groups who are managed with antidepressants should be monitored for emergence or worsening of suicidal thoughts or behaviors after any change in dosage.
4. When prescribing antidepressants for patients at risk for suicide, pay attention to the risk of overdose and limit the amount of medication dispensed and refilled.

See the VA/DoD clinical practice guideline for management of major depressive disorder (MDD) and the VA/DoD clinical practice guideline for management of bipolar disorder in adults.

M2. Use of Antipsychotics to Prevent Suicide in a Patient with a Non-Psychotic Disorder

> Closely monitor patients for changes in thoughts of suicide or suicidal behaviors after an antipsychotic is added to treatment for a mood disorder.

1. There is no evidence that antipsychotics provide additional benefit in reducing the risk of suicidal thinking or behavior in patients with co-occurring psychiatric disorders. Treatment for the psychiatric disorder should be optimized according to evidence-based guidelines for the respective disorder.

2. Patients who are treated with antipsychotics should be monitored for changes in behavior and emergence of suicidal thoughts during the initiation phase of treatment or after any change in dosage.
3. When prescribing antipsychotics in patients at risk for suicide pay attention to the risk of overdose and limit the amount of medication dispensed and refilled.

M3. Use of Lithium for Reducing Suicide in Patients with Unipolar Depressive Disorder

Providers should consider treating patients with a unipolar depression disorder with lithium in an effort to reduce the risk of suicide.

1. Lithium augmentation should be considered for patients diagnosed with unipolar depressive disorder who have had a partial response to an antidepressant and for those with recurrent episodes who are at high risk for suicidal behavior, provided they do not have a contraindication to lithium use and the potential benefits outweigh the risks. [C]
2. Lithium should be avoided or used with caution in patients with impaired renal function, those taking concurrent medications that increase or decrease lithium concentrations or those with other risk factors for lithium toxicity.
3. When prescribing lithium to patients at risk for suicide, it is important to pay attention to the risk of overdose by limiting the amount of lithium dispensed and the form in which it is provided.

M4. Use of Lithium for Reducing Suicide in Patients with Bipolar Disorder

Providers should consider treating patients with a bipolar disorder with lithium in an effort to reduce the risk of suicide.

1. Lithium should be considered for patients diagnosed with bipolar disorder who do not have contraindications to lithium as it has been shown to reduce the increased risk of suicide associated with this illness. [B]
2. Lithium should be avoided or used with caution in patients with impaired renal functions, taking concurrent medications that increase or decrease lithium concentrations or other risk factors for lithium toxicity.
3. When prescribing lithium to patients at risk for suicide, it is important to pay attention to the risk of overdose by limiting the amount of lithium dispensed, and to the form in which it is provided.

See the VA/DoD clinical practice guideline for management of bipolar disorder in adults.

M5. Use of Clozapine in the Treatment of a Patient with Schizophrenia Risk for Suicide

Providers should consider treating patients with schizophrenia with clozapine who have a history of suicide attempt, high risk for suicide, or who are symptomatic after two adequate trials with other antipsychotics.

1. Clozapine should be considered for patients diagnosed with schizophrenia at high risk for suicide, who do not have contraindications to clozapine, and will be compliant with all required monitoring. [C]

M6. Use of Antiepileptic Drugs (AEDs) and the Risk of Suicide

Closely monitor patients for changes in thoughts of suicide or suicidal behaviors after an AED is initiated for any indication.

1. Patients started or who are managed with AEDs should be monitored for changes in behavior and the emergence of suicidal thoughts.
2. There is no evidence that AEDs are effective in reducing the risk of suicide in patients with a mental disorder

M7. Use of Anti-anxiety Agents in Suicidal Patients

1. Use caution when prescribing benzodiazepines to patients at risk for suicide. It is important to pay attention to the risk of disinhibition from the medication, and respiratory depression (particularly when combined with other depressants) by limiting the amount of benzodiazepines dispensed. Avoid benzodiazepines with a short half-life and the long-term use of any benzodiazepine to minimize the risk of addiction and depressogenic effects.

M8. Use of Methadone and Naloxone to Reduce Death from Opioid Overdose

1. Methadone substitution therapy should be considered in opiate dependent patients to reduce the risk of death by overdose (see VA/DoD clinical practice guideline for management of substance use disorders [SUD]).
2. Providers should consider dispensing intranasal naloxone for patients with history of opioid overdose and those who are at high risk.

When dispensed, patient and family or other caregiver should be educated on the use of the intranasal naloxone to treat the overdose while waiting for the emergency team to arrive.

N. Electroconvulsive Therapy (ECT) in the Prevention of Suicide

Consider ECT for rapid resolution of suicidal symptoms in patients with major depressive disorder, manic episodes, bipolar I depression, PTSD, and acute schizophrenia.

1. ECT is recommended as a treatment option for severe episodes of major depression that are accompanied by suicidal thoughts or behaviors indicating imminent risk for suicide, considering patient preferences.
2. Under certain clinical circumstances and, considering patient preference, ECT may also be considered to treat suicidal patients with schizophrenia, schizoaffective disorder, or mixed or manic episodes of bipolar disorder.
3. The decision of whether to initiate ECT treatment should follow evidence-based recommendation for the specific disorder, and be based on documented assessment of the risks and potential benefits to the individual, including: the risks associated with the anesthetic; current co-morbidities; anticipated adverse events; and the risks of not having treatment.
4. Since there is no evidence of a long-term reduction of suicide risk with ECT, continuation or maintenance treatment with pharmacotherapy or with ECT is recommended after an acute ECT course.
5. ECT should be performed by experts in centers that are properly equipped and experienced in the treatment.
6. In general, the following conditions increase the indications to use ECT:
    a. A history of prior good response to ECT
    b. Need for rapid, definitive treatment response
    c. Risks of other treatments outweigh the risks of ECT
    d. History of poor response to medication treatment
    e. Intolerable side effects to medication treatments
    f. Patient preference
7. The risk-versus-benefits ratio must be considered in patients with relative contraindications such as [B]:
    a. Space occupying lesions
    b. Elevated intracranial pressure
    c. Cardiovascular problems to include recent myocardial infarction, severe cardiac ischemic disease, or profound hypertensive illness
    d. Degenerative skeletal disease
    e. Monoamine oxidase inhibitors should be discontinued two weeks prior to ECT to prevent possible hypertensive crisis.
    f. Lithium: Patients may develop neurotoxic syndrome with confusion, disorientation, and unresponsiveness.
    g. Retinal detachment
    h. Pheochromocytoma
    i. High anesthesia risk: American Society of Anesthesiologists level 4 or 5

Module D: Follow-up and Monitoring of Patient at Risk for Suicide

O. Follow-up and Monitoring

Follow patients at risk of suicide regularly and reassess risk frequently, particularly when the patient's situation changes. Follow-up should commence in the immediate period after discharge from acute care settings. The frequency of contact should be determined on an individual basis, and increased when there are increases in risk factors or indicators of suicide risk. Support should include reinforcement of the safety plan at regular intervals, including practice and, if needed, revisions. Contact and support can be helpful even when telephone, letters, or brief intervention provides it.

Follow-Up

1. Establish timely and ongoing follow-up care for those who attempt suicide and others at high acute risk in the immediate period after discharge from acute care settings and identify the responsible provider during this period.
2. Patient should be re-evaluated following an inpatient or Emergency Department discharge, as soon as possible, but not later than 7 days.
3. High acute risk patient should be actively managed to assure adherence and coordinated care.

4. Patients at high acute risk should be followed closely (e.g., weekly for the first month) after they are identified or after inpatient or Emergency Department discharge.
5. Consider contacting the patient before initial follow-up appointment to monitor transition to the outpatient care plan and to reinforce adherence to the discharge plan.
6. The frequency of outpatient follow-up should be determined on a case-by-case basis. It should be greatest after attempts and related behaviors, after change in treatment, or after transitions to a less restrictive setting of care. Once the patient stabilizes and is engaged in care the frequency of follow-up can be decreased based on:
    a. The current level of risk
    b. The requirement of the treatment modality
    c. The patient's preference

Duration of Care Focused on Suicide Prevention

7. Patients who survived a suicide attempt or identified as high acute risk for suicide should be monitored for at least one year. Patients identified as intermediate acute risk for suicide (who have never engaged in suicidal behaviors) should be followed for at least six months after suicidal ideation has resolved. Patients who have been identified as low acute risk may be followed by their primary care provider and periodically re-assessed for suicide risk.

P. Reassessment and Monitoring
1. Follow-up appointments should include:
    a. Reassessment of: interim events; changes in suicide risk; symptoms of mental disorder; and medical conditions
    b. Provision of specific treatment targeting suicidality
    c. Continuation of treatment of co-occurring underlying conditions
    d. Monitoring the symptoms of co-occurring conditions
    e. Assessment of adherence and adverse effects
    f. Modification of treatment, as indicated
    g. Support, reinforcement, and update of the safety plan
    h. Addressing patient/family concerns
    i. Determination of the frequency of future follow-up

Q. Adherence to Treatment and Follow-up Care Strategies
1. A follow-up care plan should be developed with input from the patient and, where appropriate, available support system (e.g., family, unit, friends), to address the treatment of conditions that may have contributed to the risk of suicide.
2. Follow-up care should be coordinated by an interdisciplinary team and communicated with the patient through a single identified point of contact.
3. Barriers to adherence to the care plan after discharge may be addressed by follow-up programs that include the use of:
    a. Telecommunications (phone, web based, v-tel) [I]
    b. Mailing multiple "caring letters" [I]
    c. Community workers reaching out to those at high acute risk
    d. Methods to enhance and facilitate access to care ("Green cards") [I]
    e. Home visits to support engagement [I]
    f. A facility-based registry of all high acute risk patients [I]

Patients Who Refuse Care

4. Patients who continue to be at risk for suicide and do not arrive to their follow-up appointment require a reassessment of risk, since not showing may demonstrate a risk behavior. The assessment should include: locating the patient and establishing contact, reassessment of level of risk, reinforcement of the safety plan, and directing the patient to the appropriate level of care.
5. If patient contact cannot be established, available data should be used to reassess the level of risk and corresponding effort should be made to locate the patient though direct contacts (e.g., next of kin), other points of available contacts (friends, peers, command), or, in cases of high acute risk, local emergency response (mobile crisis team, law enforcement).
6. Consider the use of caring letters for suicide attempters who refuse treatment. [I]
7. Home visit may be considered to support re-engagement of patients at high acute risk who discontinue outpatient care. [C]

R. Continuity of Care

R1. Coordination and Collaboration of Care

1. When patients are identified in primary care with intermediate or high acute risk for suicide they should be evaluated by behavioral

health providers. Warm handoffs are helpful in ensuring that patients receive the evaluations they require without interruption.

2. All providers involved in the patient's care must actively attempt to connect with others in the suicidal patients' chain of healthcare (e.g., primary care) and with the patient's consent, helping services network (e.g., chaplains) to ensure timely communication, coordination of care, and aftercare.
3. As patients are recovering from crisis and reduce their risk for suicide they may also be transitioning to less restrictive care settings, as to routine care by primary clinicians. It is the responsibility of the healthcare team to update the patient's written Safety Plan over time.

R2. Documentation of Clinical Care

4. Adequate clinical documentation of the care provided to suicidal patients is required for optimizing continuity of care. Providers must consider ethical, clinical, and legal issues when documenting their assessment, management and treatment of suicidal patients.

S. Monitoring after Recovery

1. Patients with a history of suicide attempt or behavior should continue to be evaluated for risk of relapse on a regular base.

Definitions:

Level of Evidence

I	At least one properly done randomized controlled trial (RCT)
II-1	Well-designed controlled trial without randomization
II-2	Well-designed cohort or case-control analytic study, preferably from more than one source
II-3	Multiple time series evidence with/without intervention, dramatic results of uncontrolled experiment
III	Opinion of respected authorities, descriptive studies, case reports, and expert committees

Overall Quality

Good	High grade evidence (I or II-1) directly linked to health outcome
Fair	High grade evidence (I or II-1) linked to intermediate outcome *or* Moderate grade evidence (II-2 or II-3) directly linked to health outcome
Poor	Level III evidence or no linkage of evidence to health outcome

Net Effect of the Intervention

Substantial	More than a small relative impact on a frequent condition with a substantial burden of suffering *or* A large impact on an infrequent condition with a significant impact on the individual patient level
Moderate	A small relative impact on a frequent condition with a substantial burden of suffering *or* A moderate impact on an infrequent condition with a significant impact on the individual patient level
Small	A negligible relative impact on a frequent condition with a substantial burden of suffering *or* A small impact on an infrequent condition with a significant impact on the individual patient level
Zero or Negative	Negative impact on patients *or* No relative impact on either a frequent condition with a substantial burden of suffering, or an infrequent condition with a significant impact on the individual patient level

Final Grade of Recommendation

	The Net Benefit of the Intervention			
Certainty in the Quality of Evidence	Substantial	Moderate	Small	Zero or negative
High	A	B	C	D
Moderate	B	B	C	D
Low	I	I	I	I

Strength of Recommendations Rating

A	A strong recommendation that the clinicians provide the intervention to eligible patients. *Good evidence was found that the intervention improves important health outcomes and concludes that benefits substantially outweigh harm.*
B	A recommendation that clinicians provide (the service) to eligible patients. *At least fair evidence was found that the intervention improves health outcomes and concludes that benefits outweigh harm.*
C	No recommendation for or against the routine provision of the intervention is made. *At least fair evidence was found that the intervention can improve health outcomes, but concludes that the balance of benefits and harms is too close to justify a general recommendation.*
D	Recommendation is made against routinely providing the intervention to asymptomatic patients. *At least fair evidence was found that the intervention is ineffective or that harms outweigh benefits.*
I	The conclusion is that the evidence is insufficient to recommend for or against routinely providing the intervention. *Evidence that the intervention is effective is lacking, or poor quality, or conflicting, and the balance of benefits and harms cannot be determined.*

Clinical Algorithm(s)

The following algorithms are provided in the original guideline document:

- Algorithm A: Assessment and Management of Risk for Suicide in Primary Care
- Algorithm B: Assessment and Management by Behavioral Health Care Provider
- Algorithm C: Management of Patient at High Acute Risk for Suicide

Scope

Disease/Condition(s)

Suicidal self-directed violent behavior or related suicidal ideation

Guideline Category

Counseling

Evaluation

Management

Prevention

Risk Assessment

Screening

Treatment

Clinical Specialty

Emergency Medicine

Family Practice

Internal Medicine

Preventive Medicine

Psychiatry

Psychology

Intended Users

Advanced Practice Nurses

Emergency Medical Technicians/Paramedics

Health Care Providers

Hospitals

Nurses

Pharmacists

Physician Assistants

Physicians

Psychologists/Non-physician Behavioral Health Clinicians

Public Health Departments

Social Workers

Substance Use Disorders Treatment Providers

Guideline Objective(s)

- To reduce current unwarranted practice variation and provide facilities with a structured framework to help improve patient outcomes (prevent suicide and other forms of suicidal self-directed violent behavior)
- To provide evidence-based recommendations to assist providers and their patients in the decision-making process
- To identify outcome measures to support the development of practice-based evidence that can ultimately be used to improve clinical guidelines
- To promote evidence-based management of patients presenting with suicidal self-directed violence behavior
- To promote efficient and effective assessment of patients' risks
- To identify efficacious intervention to prevent death in individuals presenting with suicidal self-directed violence behavior
- To identify the critical decision points in management of patients at risk for suicidal self-directed violence
- To promote evidence-based management of individuals with (post-deployment) health concerns and behaviors related to suicidal self-directed violence
- To inform local policies or procedures, such as those regarding referrals to or consultation with specialists

- To motivate administrators at each of the federal agencies and patient care access sites to develop innovative plans to break down barriers that may prevent patients from having prompt access to appropriate assessment and care

Target Population

Adult patients (18 years or older) with suicidal self-directed violent behavior or related suicidal ideation (identified as being at risk for suicide) who are managed in the Department of Veterans Affairs (VA) and Department of Defense (DoD) healthcare clinical settings. The population at risk includes patients who have suicidal ideation with or without an established diagnosis of a mental or substance use disorder and patients with any level of risk for suicide ranging from thoughts of death or suicide to self-directed violent behavior or suicide attempt.

Interventions and Practices Considered

Risk Assessment/Evaluation/Screening

1. Assessment of risk for suicide
2. Assessment of suicidal ideation, intent, and behavior (including warning signs)
3. Assessment of factors that contribute to the risk for suicide (risk factors/precipitants, impulsivity, protective factors, substance abuse and disorder, access to lethal means)
4. Determining the level of risk (severity of suicidality)
5. Suicide risk assessment instruments
6. Detection, recognition and referral (in primary care)
7. Comprehensive assessment for risk for suicide by behavioral health provider

Treatment/Management

Initial Management

1. Determining the appropriate care setting
    - Matching care level to level of risk
    - Criteria for transition to less restrictive settings
    - Hospitalization
    - Partial hospitalization, intensive outpatient programs (IOPs)
    - Discharge planning
2. Securing patient's safety
    - Education for patient and family
    - Limiting access to lethal means (firearms, drugs, toxic agents, other)
    - Safety plan for patient at risk of suicide
    - No-suicide contracts
    - Addressing needs (engaging family, community; spiritual and socioeconomic resources)
    - Additional steps for management of military service member

Treatment

1. Determining the treatment plan
2. Suicide-focused psychotherapy addressing the suicide risk
3. Psychotherapy for co-occurring mental disorder (borderline personality disorder [BPD], schizophrenia, comorbid substance use disorder [SUD])
4. Pharmacotherapy to reduce risk of suicide
    - Antidepressants
    - Antipsychotics
    - Lithium
    - Clozapine
    - Antiepileptic drugs
    - Anti-anxiety drugs
    - Methadone and naloxone for opioid overdose

5. Electroconvulsive therapy (ECT)

Follow-up and Monitoring

1. Establishing timely follow-up
2. Duration of care focused on suicide prevention
3. Reassessment and monitoring
4. Adherence to treatment and follow-up care strategies
    - Case- or care-management strategy
    - Facilitating access to care after discharge
    - Communication of caring messages (mailing letters/postcards)
    - Telephone contact
    - Outreach in the patient's home
    - Assertive outreach
    - Counseling and psychosocial interventions other than manual-driven psychotherapies
5. Continuity of care
    - Coordination and collaboration of care
    - Documentation of clinical care
6. Monitoring after recovery

Major Outcomes Considered

- Sensitivity and specificity of screening tools
- Effectiveness of treatment
- Incidence and rates of suicide

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Searches of Unpublished Data

Description of Methods Used to Collect/Select the Evidence

After orientation to the goals and scope of the guideline, the Working Group (WG) developed researchable questions within the focus areas of the guideline and identified associated key terms. For this guideline, two sets of questions were developed. The first (A) addressed assessment risk factors for suicide in veterans and military population. The second set (B) focused on effectiveness of specific interventions for reducing rates of suicidal self-directed violence in military and veteran populations. This approach ensured that the guideline development work outside of meetings focused on issues that practitioners considered important and also produced criteria for the literature search and selection of included studies that formed the body of evidence for this guideline. All questions specified (adapted from the Evidence-Based Medicine toolbox, Center for Evidence-Based Medicine [http://www.cebm.net]):

- Population – Characteristics of the target patient population
- Intervention – Exposure, diagnostic, or prognosis
- Comparison – Intervention, exposure, or control used for comparison
- Outcome – Outcomes of interest

These specifications served as the preliminary criteria for selecting studies. See *PICO Questions to Guide Literature Search* in Appendix A of

the original guideline document for a complete listing and categorization of the questions.

The WG relied heavily on the following publications in the development of the guideline:

- The DoD Task Force on the Prevention of Suicide by Members of the Armed Forces, established by the Fiscal Year 2009 National Defense Authorization Act. The Final Report (August 2010) made several recommendations regarding suicide prevention. A multidisciplinary panel of experts from DoD, VA, Health and Human Services (SAMHSA), and academia agreed upon these recommendations. Recommendation 59 stated:
  - Recommendation 59: *Develop clinical practice guidelines* to promote the utilization of evidence-based practices for the assessment, management, and treatment of suicide-related behaviors.
- Ramchand, Rajeev, Joie Acosta, Rachel M. Burns, Lisa H. Jaycox and Christopher G. Pernin. The War Within: Preventing Suicide in the U.S. Military. Santa Monica, CA: RAND Corporation, 2011. Available from: http://www.rand.org/pubs/monographs/MG953.html
- NICE (2011) - National Institute for Health and Clinical Excellence. Self-harm: Longer-term Care and Treatment of Self-harm: NICE clinical guideline 133. London (UK): National Health Service; 2011. Available from: www.nice.org.uk/CG133

Literature Search

Two groups have reviewed the body of research on suicide prevention approaches previously. Three systematic reviews were conducted of literature related to suicidal self-directed violence published since those two prior reports on the topic published in 2004 and 2005. The first review focused on veterans and members of the military and was conducted by the Department of Veterans Affairs (VA) Evidence-based Synthesis Program and published in 2009. The review considered studies reporting direct effects of interventions on suicide attempts or completions. Studies reporting results from any country for military or veterans were included, as were studies in Anglo/American countries with adult populations reporting interventions other than strictly mental health interventions. The other two reviews were conducted by the VA Evidence-based Synthesis Program (ESP) to specifically address the PICO questions developed by the WG. They also focused on countries and populations of interest similar to US veteran and military populations and included randomized clinical trial intervention studies of pharmacotherapy, psychotherapy, follow-up and referral. Additional studies that were reviewed were observational studies identifying risk factors for suicide and studies evaluating the validity of assessment. The two reviews were published by the VA ESP in two reports.

To identify relevant systematic reviews and controlled trials, the review searched PubMed, PsycINFO, the Cochrane Database of Systematic Reviews, and the Cochrane Central Register of Controlled Trials, and covered the period from January 2005 to November 18, 2011. The search strategy was similar to that used for the 2005 and 2004 reports. The search included suicide and all related terms; risk assessment, screening and validity, interventions and Veteran populations as search terms. The search was limited to peer-reviewed articles involving human subjects and published in the English language that were not included in previously published systematic reviews on the topic.

To assure that the search did not miss relevant articles on suicidal self-directed violence assessment and management, additional articles were obtained from systematic reviews, reference lists of pertinent studies, reviews, editorials, and consulting experts.

Selection of Evidence

The evidence selection process was designed to identify the best available evidence to address each key question and ensure maximum coverage of studies at the top of the hierarchy of study types. Published, peer-reviewed randomized controlled trials (RCTs), as well as meta-analyses and systematic reviews that included randomized controlled studies, were considered to constitute the strongest level of evidence in support of guideline recommendations. This decision was based on the judgment that RCTs provide the clearest, most scientifically sound basis for judging comparative efficacy. The WG also recognized the limitations of RCTs, particularly considerations of generalizability with respect to patient selection and treatment quality. When available, the search sought out critical appraisals already performed by others that described explicit criteria for deciding what evidence was selected and how it was determined to be valid. The sources that have already undergone rigorous critical appraisal include Cochrane Reviews, Best Evidence, Technology Assessment, Agency for Healthcare Research and Quality (AHRQ) systematic evidence reports, and other published Evidence-based Clinical Practice Guidelines.

The WG also reviewed larger syntheses of the literature that are guiding work in suicide prevention nationally and internationally, as well as an unpublished (at the time) synthesis of the literature produced by the National Institute of Health in the UK (draft self-harm clinical practice guidelines from the National Institute for Health and Care Excellence [NICE] 2011), and a draft of the systematic evidence review for the U.S. Preventive Services Task Force that was shared for review in progress of updating the earlier 2004 review. These additional searches and reviews of documents were done in an attempt to include any articles reporting on any strategies addressing suicidal self-directed violence as an outcome and to obtain the most comprehensive list of articles possible.

The following inclusion criteria were used to select the articles identified in the literature for possible inclusion:

- Published in United States, United Kingdom, Europe, Australia, Japan, New Zealand
- Full articles only published in English
- Study populations: age limited to adults 18 years of age or older; all races, ethnicities, and cultural groups
- Relevant outcomes able to be abstracted from the data presented in the articles
- Sample sizes appropriate for the study question addressed in the paper. RCTs were included if they were initiated with 30 or more participants

Search Result

An initial global literature search yielded 23 systematic reviews/meta-analyses and 38 eight RCTs (reported in 47 publications) addressing pharmacotherapy, psychotherapy, referral and follow-up interventions.

For studies addressing the key questions regarding risk factors and assessment tools, 30 observational studies and 14 systematic reviews (reported in 16 publications) were considered. Refinement of the review process with input from the WG members resulted in the studies being identified that met the baseline criteria for inclusion, addressed one or more of the researchable questions, and covered topic areas that had either not been addressed in the previous reviews or had been included but not fully developed. A more detailed search was conducted on each question, supplemented by hand searches and cross-referencing to search for relevant articles. The searches for these questions covered the period since the end search date of the evidence reports (between November 2011 and August 2012).

Number of Source Documents

A total of 35 randomized controlled studies and 38 systematic reviews were included.

Methods Used to Assess the Quality and Strength of the Evidence

Expert Consensus

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Level of Evidence

I	At least one properly done randomized controlled trial (RCT)
II-1	Well-designed controlled trial without randomization
II-2	Well-designed cohort or case-control analytic study, preferably from more than one source
II-3	Multiple time series evidence with/without intervention, dramatic results of uncontrolled experiment
III	Opinion of respected authorities, descriptive studies, case reports, and expert committees

Overall Quality

Good	High grade evidence (I or II-1) directly linked to health outcome
Fair	High grade evidence (I or II-1) linked to intermediate outcome *or* Moderate grade evidence (II-2 or II-3) directly linked to health outcome
Poor	Level III evidence or no linkage of evidence to health outcome

Net Effect of the Intervention

Substantial	More than a small relative impact on a frequent condition with a substantial burden of suffering *or* A large impact on an infrequent condition with a significant impact on the individual patient level
Moderate	A small relative impact on a frequent condition with a substantial burden of suffering *or* A moderate impact on an infrequent condition with a significant impact on the individual patient level
Small	A negligible relative impact on a frequent condition with a substantial burden of suffering *or* A small impact on an infrequent condition with a significant impact on the individual patient level
Zero or Negative	Negative impact on patients *or* No relative impact on either a frequent condition with a substantial burden of suffering, or an infrequent condition with a significant impact on the individual patient level

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review with Evidence Tables

Description of the Methods Used to Analyze the Evidence

Evidence tables were developed to demonstrate the study characteristics and results for all included studies, organized by key question and study design. The Working Group (WG) critically analyzed studies to compare their characteristics, methods, and findings; compiled a summary of findings for each key question; and drew conclusions based on qualitative synthesis of the findings. The reports included findings as described in the prior systematic reviews and the National Institute for Health and Care Excellence (NICE) 2011 draft report on self-harm in order to assess contributions of pre-2005 and non-Veteran, non-military literature to this report. Due to the differences in scope and methods in these other reports, data synthesis of the findings is limited to a narrative summary.

Recommendation and Quality Rating

Evidence-based practice involves integrating clinical expertise with the best available clinical evidence derived from systematic research.

The results of the searches, the evidence tables, and copies of the original studies were provided to the WG for further analysis. The clinical experts from the Department of Veterans Affairs (VA) and Department of Defense (DoD) WG reviewed the results and evaluated the strength of the evidence, considering quality of the body of evidence (made up of the individual studies) and the significance of the net benefit (potential benefit minus possible harm) for each intervention.

The overall strength of each body of evidence that addresses a particular Key Question was assessed using methods adapted from the U.S. Preventive Services Task Force (USPSTF) (2001). To assign an overall quality (QE) (see the "Rating Scheme for the Strength of Evidence" field) of the evidence (good, fair, or poor), the number, quality, and size of the studies; consistency of results between studies; and directness of the evidence were considered. Consistent results from a number of higher-quality studies (LE) (see the "Rating Scheme for the Strength of Evidence" field) across a broad range of populations supports with a high degree of certainty that the results of the studies are true and therefore the entire body of evidence would be considered "good" quality. A "fair" quality was assigned to the body of evidence indicating that the results could be due to true effects or to biases present across some or all of the studies. For a "poor" quality body of evidence, any conclusion is uncertain due to serious methodological shortcomings, sparse data, or inconsistent results.

Methods Used to Formulate the Recommendations

Expert Consensus

Expert Consensus (Nominal Group Technique)

Informal Consensus

Description of Methods Used to Formulate the Recommendations

The Department of Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline for Assessment and Management of Risk for Suicide was developed following the general strategy described in "Guideline for Guidelines," an internal working document of the VA/DoD Evidence-Based Practice Working Group, that requires an ongoing review of guideline works in progress.

The Offices of Quality Safety and Values and Patient Care Services of the VA, and the Army Medical Command of the DoD identified clinical leaders to champion the guideline development process. During a preplanning conference meeting, the clinical leaders defined the scope of the guideline and identified a group of clinical experts from the VA and DoD to form the Assessment and Management of Risk for Suicide Working Group (WG). The WG's participants were drawn from the fields of primary care, psychiatry, psychology, pharmacology, nursing, and social work.

Recommendations for assessment of suicide risk and management of patients at risk for suicide were derived through a rigorous methodological approach that included the following:

- Determining appropriate criteria such as effectiveness, efficacy, and patients benefit
- Reviewing literature to determine the strength of the evidence in relation to these criteria
- Formulating the recommendations and grading the level of evidence supporting the recommendation

Working Group Meetings

The WG participated in a 4-day face-to-face meeting to reach consensus about the guideline algorithm and evidence-based recommendations and to prepare a draft document. The draft continued to be revised by the WG through numerous conference calls and individual contributions to the document. The group was divided to several subtask groups that focused on different aspects of the guideline (i.e., recommendation for pharmacotherapy, psychotherapy, assessment, etc.)

The plenary group convened to discuss discrepancies in opinion and interpretation of the evidence. In most cases, an informal consensus within the WG was sufficient to formulate recommendations based on the best evidence and/or experience of the clinical experts. In areas where this approach did not lead to conclusion, the facilitator used a structured discussion format (i.e., a modified nominal group process) to expedite the process and reach consensus based on the collective experience of the group. Where existing literature was ambiguous, or where scientific data was lacking on an issue, the recommendations were based on the clinical experience of the WG.

Formulation of Recommendations

This Guideline is the product of many months of diligent effort and consensus building among knowledgeable individuals from the VA and DoD. An experienced moderator facilitated the multidisciplinary WG. The guideline was developed, reviewed and evolved over three major iterations. The entire WG developed consensus for the scope and structure of the guideline. The co-chairs and subject matter experts reviewed the available evidence, and collectively completed and reviewed the first draft of recommendations based on the available evidence. The Recommendations were sent to the whole WG for comment. Comments and modifications of the text suggested by the members of the WG were integrated into a second draft that was again reviewed for clarity and consistency by the co-chairs. Suggested changes to the algorithm and annotation were discussed over conference calls until all disagreements were resolved and the entire group achieved a consensus.

Recommendation and Quality Rating

The Strength of Recommendation (SR) was determined based on the Quality of the Evidence (QE), and the clinical significance of the net benefit (NB) (see the "Rating Scheme for the Strength of the Evidence" field) for each intervention, as demonstrated by the body of evidence. Thus, the grade (i.e., A, B, C, D or I) assigned to guideline recommendations reflect both variables; the quality of the evidence and the potential clinical benefit that the intervention may provide to patients (see the "Rating Scheme for the Strength of Recommendations" field).

Due to the limitation in the evidence and the quality of the studies the WG preferred to grade some recommendation using a grade [I] rather than a grade [D] as a result of limited options and no alternative interventions in some cases despite the lack of demonstrated net benefit.

Rating Scheme for the Strength of the Recommendations

Final Grade of Recommendation

	The Net Benefit of the Intervention			
Certainty in the Quality of Evidence	Substantial	Moderate	Small	Zero or negative
High	A	B	C	D
Moderate	B	B	C	D
Low	I	I	I	I

Strength of Recommendations Rating

A	A strong recommendation that the clinicians provide the intervention to eligible patients. *Good evidence was found that the intervention improves important health outcomes and concludes that benefits substantially outweigh harm.*
B	A recommendation that clinicians provide (the service) to eligible patients. *At least fair evidence was found that the intervention improves health outcomes and concludes that benefits outweigh harm.*
C	No recommendation for or against the routine provision of the intervention is made. *At least fair evidence was found that the intervention can improve health outcomes, but concludes that the balance of benefits and harms is too close to justify a general recommendation.*
D	Recommendation is made against routinely providing the intervention to asymptomatic patients. *At least fair evidence was found that the intervention is ineffective or that harms outweigh benefits.*
I	The conclusion is that the evidence is insufficient to recommend for or against routinely providing the intervention. *Evidence that the intervention is effective is lacking, or poor quality, or conflicting, and the balance of benefits and harms cannot be determined.*

Cost Analysis

The guideline developers reviewed published cost analyses.

Method of Guideline Validation

External Peer Review

Internal Peer Review

Description of Method of Guideline Validation

The content and validity of each section of the guideline was thoroughly reviewed in a series of conference calls. The final document is the product of those discussions and has been approved by all members of the Working Group.

The second draft was sent to stakeholders in the Veterans Health Administration, and the Departments of Army, Navy (and US Marine Corps), and Air Force for comment. These comments were again reviewed and integrated by the co-chairs and a final review was performed to ensure consistency of recommendations with the available evidence for this guideline.

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified for selected recommendations (see the "Major Recommendations" field).

The final guideline document represents a synthesis of current scientific knowledge and rational clinical practice on the assessment and treatment of adult patients with risk for suicide. Where existing literature was ambiguous or conflicting, or where scientific data were lacking on an issue, recommendations were based on the clinical experience of the Working Group.

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

- Appropriate assessment of patients' risk factors for suicide
- Improved intervention to prevent death in individuals at risk of suicide

Potential Harms

- The aim of hospitalization is to provide immediate, shortâ€term safety for suicidal individuals, and begin to implement treatment; however, hospital admission itself is associated with several potential risks, including stigmatization. This can be highly detrimental for some individuals who may already be dealing with extremely low selfâ€esteem, by increasing their experience of being marginalized and alienated. The risks associated with hospitalization are not limited to the patient at high risk for suicide, but also to the potentially negative effect of hospitalization on the outcome for those diagnosed with major psychiatric disorders. For some, such as those with borderline personality disorder, inpatient admission has the potential to foster dependence, exacerbating their symptoms and risk for suicide.
- Electroconvulsive therapy (ECT) is not without risk, which includes both adverse outcomes such as death in .002% and adverse side effects including temporary confusion and memory loss. Modern ECT techniques have substantially reduced the memory effects experienced by most patients. ECT death is usually the result of cardiovascular complications in patients who are already having cardiovascular compromise. Fractures are minimized by the use of muscle relaxants; however, teeth may still be broken during the treatment. Headaches and muscle soreness are usually relieved by non-steroidal anti-inflammatory drugs (NSAIDs) and nausea by anti-emetics. Seventy-five percent of patients report that memory impairment is the worse side effect they experience.
- Disadvantages of assessment tools in general
    - Forms are no substitute for spending time to know the patient
    - Only a few single suicide risk assessment methods have been empirically tested for reliability and validity
    - Standard practice encompasses a wide range of reasoned clinical approaches. The clinician's duty is to perform a competent suicide risk assessment by using a reasonable method.
    - When substituted for clinical assessment, forms can increase the risk of missing a patient's suicidal intent.
    - Forms tend to be focused on an event, whereas clinical assessment is a process.
    - The best scales cannot perform the integrative function of clinical assessment and judgment.
    - The range of general and individual suicide risk factors cannot be captured by any instrument, regardless of how sophisticatedly constructed.
    - May result in false positive that may lead to unnecessary or harmful interventions
    - Can take valuable clinical time to complete (especially in primary care) and negatively affect patient satisfaction.

Adverse Effects of Medications

- In one study, use of an antidepressant by patients younger than 25 years was associated with an increased suicidal behavior compared to those assigned to placebo. Young adults (18 to 24) started on an antidepressant for treatment of depression or another psychiatric disorder should be monitored and observed closely for emergence or worsening of suicidal thoughts or behaviors during the initiation phase of treatment.
- Patients who are treated with antipsychotics should be monitored for changes in behavior and emergence of suicidal thoughts during the initiation phase of treatment or after any change in dosage.
- Lithium should be avoided or used with caution in patients with impaired renal function, those taking concurrent medications that increase or decrease lithium concentrations or those with other risk factors for lithium toxicity.
- When prescribing antidepressants, antipsychotics, or lithium to patients at risk for suicide, it is important to pay attention to the risk of overdose and limit the amount of medication dispensed.
- Clozapine's adverse effect profile is not benign as it has strong anticholinergic properties, is associated with metabolic effects including weight gain and glucose intolerance, sialorrhea, agranulocytosis, and myocarditis.

- Patients started or who are managed with antiepileptics should be monitored for changes in behavior and the emergence of suicidal thoughts.
- Benzodiazepines can be effective in treating symptoms of anxiety, insomnia, hypervigilance, and other anxiety symptoms. In general, benzodiazepines are not recommended for long-term use in chronic aggression because of the potential for dependence and tolerance, resulting in an increase in impulsivity-aggression. Benzodiazepines can occasionally disinhibit aggressive and dangerous behaviors and enhance impulsivity. Benzodiazepines taken in excessive amounts can cause overdose and dangerous deep unconsciousness. In combination with other central nervous system depressants, such as alcohol and opiates, the potential for toxicity increases exponentially.

Contraindications

Contraindications

Relative contraindications to electroconvulsive therapy (ECT) include:

- Space occupying lesions
- Elevated intracranial pressure
- Cardiovascular problems to include recent myocardial infarction, severe cardiac ischemic disease, or profound hypertensive illness.
- Degenerative skeletal disease
- Monoamine oxidase inhibitors should be discontinued two weeks prior to ECT to prevent possible hypertensive crisis
- Lithium: patients may develop neurotoxic syndrome with confusion, disorientation, and unresponsiveness
- Retinal detachment
- Pheochromocytoma
- High anesthesia risk: American Society of Anesthesiologists level 4 or 5

Pregnancy is not an absolute contraindication to ECT.

Qualifying Statements

Qualifying Statements

- The Department of Veterans Affairs (VA) and The Department of Defense (DoD) guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision-making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.
- Variations in practice will inevitably and appropriately occur when providers take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every health care professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.
- After assessing evidence quality for suicide prevention, researchers concluded, "there is a lack of strong evidence for any interventions in preventing suicide and suicide attempts." Two core challenges markedly diminish quality of evidence in suicide prevention research: difficulty conducting randomized controlled trials, and low base rates of suicide and suicide attempts, even in groups at higher risk for suicide.

Implementation of the Guideline

Description of Implementation Strategy

While these clinical practice guidelines propose potentially universal approaches for enhancing accurate assessment of risk for suicide and effective prevention of deaths by suicide, their implementation is intended for the unique government environments of Military and Veteran medical systems. Such uniqueness includes the evolution over the past several years of considerable investments to prevent suicide at multiple levels of each Department. Veterans Affairs and Department of Defense (VA/DoD) suicide preventionists have co-presented academic research on suicide prevention at each Department's mental health/suicide prevention conferences. VA/DoD subject matter experts attend the monthly DoD Suicide Prevention and Risk Reduction Committee (SPARRC) meetings to coordinate and share initiatives. A common VA/DoD suicide prevention

website was developed and hosted (http://www.suicideoutreach.org). In addition, VA clinicians increasingly provided both preventive and medical care to Reserve Component Service members. For example, VA providers address suicide prevention while conducting post-deployment health assessments (including mental health) for Reserve Component Service members returning from combat deployments. Additionally, Congress extended the eligibility for health care in the Veterans Health Administration (VHA) to five years from discharge or separation date from active duty and activated members of the National Guard and Reserve who served in Operations Iraqi or Enduring Freedom (OEF/OIF/OND), leading to many Service members receiving their routine and behavioral health care in VHA facilities.

Training

The Institute of Medicine (IOM) report *Improving the Quality of Health Care for Mental and Substance Use Conditions* documents the wide variations and problems in training all categories of mental health professionals. This IOM report describes the remarkable inadequacies of curricula, course design, and continuing education.

Unfortunately, there is a shortage of clinicians trained to provide evidence-based psychotherapies. Some experts believe that until clinical training programs for the major mental health disciplines include training in these evidence-based therapies, the gap between research and clinical practice will remain.

- Training in suicide risk assessment and management of patients who self-harm should be a core competency for all providers. It should be an essential component of prequalification training.
- Providers who are exposed to people who harm themselves should have access to experienced colleagues for consultation and assistance in management of difficult cases.
- Primary Care and General Medical Care providers should have access to Behavioral Health experts in evaluation and managing patient at risk for suicide.

Implementation Tools

Clinical Algorithm

For information about availability, see the *Availability of Companion Documents* and *Patient Resources* fields below.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Living with Illness

Staying Healthy

IOM Domain

Effectiveness

Patient-centeredness

Safety

Timeliness

Identifying Information and Availability

Bibliographic Source(s)

Assessment and Management of Risk for Suicide Working Group. VA/DoD clinical practice guideline for assessment and management of patients at risk for suicide. Washington (DC): Department of Veterans Affairs, Department of Defense; 2013 Jun. 190 p.

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2013 Jun

Guideline Developer(s)

Department of Defense - Federal Government Agency [U.S.]

Department of Veterans Affairs - Federal Government Agency [U.S.]

Veterans Health Administration - Federal Government Agency [U.S.]

Source(s) of Funding

United States Government

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The Assessment and Management of Risk for Suicide Working Group

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Financial Disclosures/Conflicts of Interest

Not stated

Guideline Status

This is the current release of the guideline.

Guideline Availability

Electronic copies: Available from the Department of Veterans Affairs Web site .

Print copies: Available from the Department of Veterans Affairs, Veterans Health Administration, Office of Quality and Performance (10Q) 810 Vermont Ave. NW, Washington, DC 20420.

Availability of Companion Documents

None available

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI Institute on August 23, 2013. The information was verified by the guideline developer on October 22, 2013. This summary was updated by ECRI Institute on September 18, 2015 following the U.S. Food and Drug Administration advisory on non-aspirin nonsteroidal anti-inflammatory drugs (NSAIDs). This summary was updated by ECRI Institute on October, 5 2015 following the U.S. Food and Drug Administration advisory on Clozapine. This summary was updated by ECRI Institute on June 2, 2016 following the U.S. Food and Drug Administration advisory on Opioid pain medicines.

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